METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS

SEP 18 2017

EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-045653

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900214

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted] →	306	11372	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

North Patrol Division, District 6, 4014 N. Union Blvd, St. Louis, MO (314)444-0001

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
9/15/17	On West Minster, east of Kingshighway	____ A.M. 10:30 P.M.	No	09:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Holding a line

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: Helmet, gasmask, shin pads

WHAT WAS EMPLOYEE DOING WHEN INJURED?

Officer [redacted] was working the Verdict Detail when a subject threw a brick stricking her in the left side of her face and head.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

Brick

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED

Dislocated jaw

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Anthony Caruso, 6743/306	4014 N. Union Blvd St. Louis, MO

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Doctor Zachary T. Hafez	Barnes Jewish Hospital #1 Barnes Jewish Plaza

NAME OF SUPERVISOR COMPLETING REPORT

Anthony Caruso

RANK Sergeant DSN 6743

ASSIGN. 306 DATE 09/16/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

Exhibit J

SEP 14 2017

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☒ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-45589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900215

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	301	11262	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
3157 Sublette St. Louis MO 63139 444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. Louis MO 63103	____ A.M. 4:00 P.M.	yes 0700 on 9/16/17	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
While engaging protestors, a suspect threw a chunk of concrete (or rock) and struck PO [redacted] on her helmet.

	YES	NO
Seat Belts Used?	☐	☐
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: cdt equipment, helmet

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Working as a member of the cdt team on a protest detail

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Chunk of concrete or large rock

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
[redacted] complained of dizziness and headache after being struck on her helmet by a rock, diagnosed with a concussion

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
PO Kanisha Coleman DSN 11268	3157 Sublette 444-0100

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Dr. Stephen Liang #1 Barnes Jewish Hospital Plaza	Barnes Hospital #1 Barnes Jewish Hospital Plaza

NAME OF SUPERVISOR COMPLETING REPORT
Sgt. Robert Lammert

RANK Sergeant DSN 5481

ASSIGN. 301 DATE 9/16/17

☐ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 21 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900216

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES / NO
[redacted]	304	3944	☒ / ☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
4th District Bike Unit
215 N. 9th St St louis Mo 63101 314-436-9645

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. St. Louis MO 63101	____ A.M. 17:05 P.M.	no	8:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
Civil unrest, Lieutenant was punched in the face and scraped left leg

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: helmet		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
partcipating in crowd control during civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
suspects fist

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
punched one time in face, scraped left leg

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
no

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Karnowski, DSN 6887	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
na	

NAME OF SUPERVISOR COMPLETING REPORT
Matt Karnowski

RANK Sgt. DSN 6887

ASSIGN 304 DATE 09/15/17

☒ WORK RELATED ☐ NOT WORK RELATED

Renee Kruemen 2815 9/20/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 21 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900217

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	304	2795	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
4th District Bike Unit
215 N. 9th St St louis Mo 63101 314-436-9645

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. St. Louis MO 63101	____ A.M. 17:05 P.M.	no	6:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text*

Civil unrest, Sergeant was assaulted by unknown suspect

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: helmet		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
partcipating in crowd control during civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
police bicycle

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
unknown suspect pushed police bicycle into [redacted] left leg

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
no

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Karnowski, DSN 6887	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
na	

NAME OF SUPERVISOR COMPLETING REPORT
Matt Karnowski

RANK Sgt. DSN 6887

ASSIGN 304 DATE 09/15/17

☒ WORK RELATED ☐ NOT WORK RELATED

Renee Kuessner 2815 9/20/17
COMMANDER'S SIGNATURE DSN DATE

SEP 21 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900218

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	*Employee Refused Treatment* YES	NO
[redacted]	302	6573	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
2nd District
3157 Sublette, St Louis Mo 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. St. Louis MO 63101	A.M. / 17:05 P.M.	no	6:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text*
Civil unrest, Sergeant injured his left thumb

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: helmet		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
partcipating in crowd control during civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
unknown

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
unknown how thumb was injured, but it was injured during crowd control measures relative to civil disobedience.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
no

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Karnowski, DSN 6887	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
na	

NAME OF SUPERVISOR COMPLETING REPORT
Matt Karnowski

RANK Sgt. DSN 6887

ASSIGN. 304 DATE 09/15/17

☒ WORK RELATED ☐ NOT WORK RELATED

Renee Kaumann 2815 9/20/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS

SEP 21 2017

EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8.00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900219

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	*Employee Refused Treatment* YES	NO
[redacted]	302	8164	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
2nd District
3157 Sublette, St Louis Mo 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. St. Louis MO 63101	____ A.M. 17:05 P.M.	no	09:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATIDN SHEET IF NEEDED) *Only allow four lines of text.*

Civil unrest, Officer was exposed to chemical pepper spray to face

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type. helmet		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
partcipating in crowd control during civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
chemical spray

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
participating in crowd control measures during civil unrest, Officer was exposed to chemical spray that was used to help disperse crowd.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
no

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Karnowski, DSN 6887	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
na	

NAME OF SUPERVISOR COMPLETING REPORT
Matt Karnowski

RANK Sgt. DSN 6887

ASSIGN. 304 DATE 09/15/17

☒ WORK RELATED ☐ NOT WORK RELATED

Renee Laussmann 315 9/21/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 21 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 17-900220

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	306	8191	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
6th District
4014 Union, St. Louis Mo 63115

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. St. Louis MO 63101	A.M. 17:05 P.M.	no	09:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
Civil unrest, Officer was exposed to chemical pepper spray to face

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: helmet		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
partcipating in crowd control during civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
chemical spray

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
participating in crowd control measures during civil unrest, Officer was exposed to chemical spray that was used to help disperse crowd.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
no

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Karnowski, DSN 6887	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
na	

NAME OF SUPERVISOR COMPLETING REPORT
Matt Karnowski

RANK Sgt. DSN 6887

ASSIGN. 304 DATE 09/15/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 21 2017.

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900220

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	*Employee Refused Treatment* YES	NO
[redacted]	306	8191	☒	☐

INJURED EMPLDYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
6th District
4014 Union, St. Louis Mo 63115

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	1200 Clark St. St. Louis MO 63101	____ A.M. 17:05 P M.	no	09:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Civil unrest, Officer was exposed to chemical pepper spray to face

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: helmet		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
partcipating in crowd control during civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
chemical spray

DESCRIBE THE INJURY DR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
participating in crowd control measures during civil unrest, Officer was exposed to chemical spray that was used to help disperse crowd.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
no

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Karnowski, DSN 6887	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATIDN SHEET FDR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
na	

NAME DF SUPERVISOR COMPLETING REPORT
Matt Karnowski

RANK Sgt. DSN 6887

ASSIGN. 304 DATE 09/15/17

☒ WORK RELATED ☐ NOT WORK RELATED

Renee Kusmanop 2315 9/26/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS

OCT 05 2017

EMPLOYEE INJURY REPORT

CHECKLIST:

☒ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # N/A

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900256

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	*Employee Refused Treatment* YES	NO
[redacted]	302	4738	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

District 2, 3157 Sublette St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/21/17	5850 Elizabeth Ave. St. Louis, MO 63110	____ A.M 3:00 P.M.	NO	2:00pm

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text*

[redacted] was unloading police equipment on 09/21 from a Tahoe and strained her lower back. On 09/24 [redacted] was unloading cases of water from a trailer unto a dept. van and again strained her back. On 10/02, she got up from a chair when her duty belt caught on the chair.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☐	☒
Specify Type:		

WHAT WAS EMPLOYEE DOING WHEN INJURED?

[redacted] was lifting heavy items during the first two incidents and the third incident she was attempting to stand from a seated position when her duty belt was stuck on the back of a chair causing lower back pain.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

Civil Disobedience Equipment, Ice Coolers, Chair

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.

[redacted] strained her lower back on three separate dates. 09/21/17, 09/24/17, 10/02/17.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.

NO

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Brian Seppi 7226, Sgt. Joe Lankford 6564, Sgt. Timothy Turner 4372	3157 Sublette Ave St. Louis, MO 63139

DDES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☒ NO ☐

NAME AND ADDRESS DF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
	Barnes Care 5000 Manchester Ave St. Louis, MO 63110

NAME OF SUPERVISDR COMPLETING REPORT

Timothy Turner

RANK Seergeant DSN 4372

ASSIGN. 302 DATE 10/04/17

☒ WORK RELATED	☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS

SEP 19 2017

EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045653

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-090022

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	302	11021	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

3157 Sublette Ave., St. Louis MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Kingshighway/Waterman	A.M. / 10:17 P.M.	Yes-Unk	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

A canister of unknown gas was thrown to [redacted] feet by an unknown demonstrator. [redacted] gas mask failed, giving him full exposure to the unknown gas. [redacted] was immediatley overwelmed by the unknown gas.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?

[redacted] was on the front line of the CDT line which was pushing demonstrators east toward Euclid.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

A canister of of unknown gas

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.

Difficulty breathing and seeing

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR DTHER PERMANENT DISABILITY? IF SO, EXPLAIN.

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Charles Wall 6956/306	4014 Union, St. Louis MO 63115 314-444-0001

DOES WITNESS CONCUR WITH THE INJUREO EMPLOYEES STATEMENT? (IF NO, USE CONTINUATIDN SHEET FOR STATEMENT, IF NEEDED)

YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME ANO ADDRESS OF HOSPITAL
Dr. Ernesto Romo	Barnes Jewish Hospital

NAME OF SUPERVISOR COMPLETING REPORT

Sgt. Charles Wall

RANK Sergeant DSN 6956

ASSIGN. 306 DATE 09/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

Capt. [signature] 5514 9/18/17

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 25 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p m – 8:00 a.m)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # **17-045653**

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # **170900222**

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted] →	306	6437	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
4014 N Union

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Waterman & Kingshighway	A.M. / 10:17 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED)
Only allow four lines of text.

[redacted] was struck with a large piece of asphalt thrown by a protester.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: Personal Protection Equip

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Supervising CDT officers on the front line.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Large piece of asphalt.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
Injury to right shoulder, righ bicep and left knee. The shoulder and bicep as a result of being struck. The knee as a result of being spun around by the impact of the blow, twisting his left knee completely around.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
Unkown at this time in regard to disability. Follow-up examinations needed.

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
PO Jermaine Banks 7519/306	4014 N. Union

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Dr. McMillan #1 Barnes Jewish Hospital Plaza	Barnes Hospital #1 Barnes Jewish Hospital Plaza

NAME OF SUPERVISOR COMPLETING REPORT
Lt. Dan Zarrick

RANK **Lieutenant** DSN **3314**

ASSIGN **306** DATE **9/22/17**

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 18 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # **17-045653**

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) # **170900222**

NAME OF INJURED EMPLDYEE	ASSIGN	DSN	*Employee Refused Treatment* YES	NO
[redacted] →	306	6437	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
4014 N. Union 444-0001

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Waterman @ Kingshighway	____ A.M. 10:17 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text*
[redacted] **was struck with a large piece of asphalt thrown by a protestor**

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: **Personal Protection Equip.**

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Supervising CDT officers on front line

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
large piece of asphalt

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
injury to right shoulder and bicep

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
No

NAME DF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
PO Jermaine Banks, 7519/306	**4014 N. Union 444-0001**

DOES WITNESS CDNCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CDNTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Dr. McMillan #1 Barnes Jewish Hospital Plaza	**Barnes Hospital #1 Barnes Jewish Hospital Plaza**

NAME OF SUPERVISOR CDMPLETING REPORT
Michael A. Mayo Jr.

RANK **Lieutenant** DSN **5485**

ASSIGN **440** DATE **9/17/17**

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 18 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # **17-045653**

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) # **170900223**

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	*Employee Refused Treatment* YES	NO
[redacted] →	303	1175	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
919 N. Jefferson

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Kingshighway & Waterman	22:17 A.M. / P.M	No	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

[redacted] **was struck in the left shoulder by an unknown hard object thrown by a protester.**

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: **CDT equipment**

WHAT WAS EMPLOYEE DOING WHEN INJURED?
[redacted] **was supervising a CDT line formation during a protest.**

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
Unknown hard object

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
Pain and soreness to shoulder; popping in shoulder when moving it.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
Unknown

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Lt. Daniel Chitwood 3677	**1915 Olive Street; 444-5968**

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
Daniel Chitwood

RANK **Lieutenant** DSN **3677**

ASSIGN. **600** DATE **9/17/17**

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 18 2017

CHECKLIST:

☒ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-45653

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 17-900224

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	*Employee Refused Treatment* YES	NO
[redacted] →	399	3973	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
Problem Properties 1915 Olive (314)444-5490

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY →	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/16/17	400 N. Euclid	1215 A.M. / P.M.	Yes	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Sergeant was struck in head with water bottle. Chemical munitions were deployed and Sergeant became dizzy and started coughing. Sergeant fell down striking his head on floor of building.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: **Helmet**

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Sergeant was deployed as part of Civil Disobedience Support Team due to civil unrest

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
Bottle of water, chemical munitions, floor of building

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
dizziness, nauseous, bothered by light

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
NO

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Janet McKern 435 DSN 3762	**1915 Olive (314) 444-5617**

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Dr. Ernesto Romo	**Barnes Hospital 1 Barnes Jewish Hospital Plaza**

NAME OF SUPERVISOR COMPLETING REPORT
Justin Johnson

RANK **Sergeant** DSN **6194**

ASSIGN. **400** DATE **09/17/17**

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 21 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☒ BarnesCare on-duty physician Immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045984

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900243

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	399	4791	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
1915 Olive St. St. Louis, MO 63103

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
9-17-17	900 Washington	A.M. / 8:40 P.M.	Yes	3PM

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer [redacted] was working in an undercover capacity in a large violent mob. As officers were making arrests, Officer [redacted] was knocked to the ground striking the concrete.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☐	☒
Other Safety Equip. Used?	☐	☒
Specify Type:		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Standing in a large violent crowd.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
street/sidewalk

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Contusions to left thigh, hip and tailbone. Contusions and abrasions to face to include cut on lip requiring stitches. Contusions and abrasions to jaw, left ear, neck and left shoulder.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
NO

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Dr. Prelutsky 2340 Hampton Ave St. Louis, MO 63139	N/A

NAME OF SUPERVISOR COMPLETING REPORT
Kevin Ahlbrand

RANK Sergeant DSN 3130

ASSIGN. 210 DATE 9-18-17

☒ WORK RELATED ☐ NOT WORK RELATED

M. Ruhl 3267 9/19/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 19 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045653

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900228

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	303	5175	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
919 N. Jefferson

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Kingshighway & Waterman	A.M. / 22:17 P.M.	No	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Sergeant [redacted] was struck in the left lower back by a brick thrown by a protester.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Sergeant [redacted] was supervising a CDT line formation during a protest.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Brick

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Pain and soreness to left lower back, huge knot and some bruising.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
Unknown

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Lt. Daniel Chitwood 3677	1915 Olive Street; 444-5968

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
Daniel Chitwood

RANK Lieutenant DSN 3677

ASSIGN. 600 DATE 9/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 19 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045653

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900227

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	302	6490	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
919 N. Jefferson

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Kingshighway & Waterman	____ A.M. 22:17 P.M.	No	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
[redacted] inhaled an unknown, chemical smoke emitting from a canister thrown by a protester.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
[redacted] was supervising a CDT line formation during a protest.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
A smoking chemical substance emitting from a canister thrown by a protester.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Eyes and nose irritated by unknown chemical smoke emitting from a canister; temporarily could not see.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
Unknown

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Lt. Daniel Chitwood 3677	1915 Olive Street; 444-5968

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
Daniel Chitwood

RANK Lieutenant DSN 3677

ASSIGN. 600 DATE 9/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 27 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-045589

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900229

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	*Employee Refused Treatment* YES	NO
[redacted] →	301	7274	☐	☒

INJURED EMPLOYEES DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
3157 Sublette

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY →	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Tucker at Clark	____ A.M. 17:25 P.M.	No	0900

HDW DID INJURY DCCUR? DESCRIBE FULLY (ATTACH CDNTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer was struck in left shoulder by a thrown object (rock or piece of concrete).

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: CDT equipment

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Officer was in a CDT line formation during a protest.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Piece of broken concrete or rock

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Soreness and discoloration to left shoulder

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
Unknown

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. James Buckeridge	3157 Sublette, 444-0133

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATIDN SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS DF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HDSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
James Buckeridge

RANK Sergeant DSN 5823

ASSIGN. 301 DATE 9/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4.30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-045653

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900230

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	301	11263	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
3157 Sublette

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Hortense at Euclid	A.M. 22:55 P.M.	No	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text*
Officer was explosed to an unknown chemical gas thrown by a protester.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Officer was in a CDT line formation during a protest.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
A smoking chemical substance emitting from a canister thrown by a protester.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
Eyes and nose irritated by unknown chemical smoke emitting from a canister.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
Unknown

NAME OF WITNESS. (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Sam Gilman, 6936	3157 Sublette, 444-0100

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
James Buckeridge

RANK Sergeant DSN 5823

ASSIGN. 301 DATE 9/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 18 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900231

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted]	301	967	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
3157 Sublette, St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Tucker/Clark	____ A.M. 3:34 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
Officer was involved in Civil Disobedience Detail

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
CDT Duties

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Unknown white substance.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
Exposure to unknown white substance.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL

NAME OF SUPERVISOR COMPLETING REPORT
Lankford, Joseph

RANK Sergeant DSN 6564

ASSIGN. 302 DATE 09/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 19 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900231

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	301	967	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
3157 Sublette, St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Tucker/Clark	3:34 A.M. / P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
Officer was involved in Civil Disobedience Detail

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
CDT Duties

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Unknown white substance.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Exposure to unknown white substance.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL

NAME OF SUPERVISOR COMPLETING REPORT
Lankford, Joseph

RANK Sergeant DSN 6564

ASSIGN. 302 DATE 09/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 19 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900232

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted]	301	8022	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
3157 Sublette, St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Tucker/Clark	3:34 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
Officer was involved in Civil Disobedience Detail

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
CDT Duties

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
Unknown white substance.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Exposure to unknown white substance.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJUREO EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL

NAME OF SUPERVISOR COMPLETING REPORT
Lankford, Joseph

RANK Sergeant DSN 6564

ASSIGN. 302 DATE 09/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 19 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900233

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	302	11469	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

3157 Sublette, St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Tucker/Clark	A.M. / 3:34 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer was involved in Civil Disobedience Detail

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: CDT Equipment

WHAT WAS EMPLOYEE DOING WHEN INJURED?

CDT Duties

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

Unknown white substance.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.

Exposnre to unknown white substance.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL

NAME DF SUPERVISOR COMPLETING REPORT

Lankford, Joseph

RANK Sergeant DSN 6564

ASSIGN. 302 DATE 09/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 19 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17045653

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900235

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	*Employee Refused Treatment* YES	NO
[redacted]	302	11095	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

3157 Sublette, St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Central West End	A.M. / 10:17 P.M.	NO	1000

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer was iuvolved in Civil Disobedience Detail

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: **CDT Equipment**

WHAT WAS EMPLOYEE DDING WHEN INJURED?

CDT Duties

NAME THE OBJECT DR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

A large rock/brick that was thrown at officers by demonstrators.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.

Officer sustained cuts on his left hand/fingers.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL

NAME OF SUPERVISOR COMPLETING REPORT

Lankford, Joseph

RANK **Sergeant** DSN **6564**

ASSIGN. **302** DATE **09/17/17**

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 18 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17045589

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900234

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	*Employee Refused Treatment* YES	NO
[redacted] →	302	11095	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHDNE NO.

3157 Sublette, St. Louis, MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Tucker/Clark	___ A.M. 3:34 P.M.	NO	0900

HDW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer was involved in Civil Disobedience Detail

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type. **CDT Equipment**

WHAT WAS EMPLOYEE DOING WHEN INJURED?

CDT Duties

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

Unknown white substance.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.

Exposure to unknown white substance.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHDNE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL

NAME OF SUPERVISOR COMPLETING REPORT

Lankford, Joseph

RANK **Sergeant** DSN **6564**

ASSIGN. **302** DATE **09/17/17**

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 20 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-045651

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 17-900236

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	*Employee Refused Treatment* YES	NO
[redacted] →	463	01645	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
Traffic Safety 1915 Olive St. Louis, Mo

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09-16-17	4900 Maryland	12:15 A.M. / P.M.	No	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
Officer [redacted] was working the Civil disobedience and driving department 557 east on Maryland when an unknown person threw a large rock, striking the frame of the driver's door and striking PO [redacted] left arm

	YES	NO
Seat Belts Used?	☒	☐
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: Reflective Vest		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Driving his patrol vehicle

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
rock/brick

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
Small scratch to left forearm

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	N/A

NAME OF SUPERVISOR COMPLETING REPORT
Edward Moran 3597

RANK Sergeant DSN 03597

ASSIGN. 463 DATE 09-17-17

☒ WORK RELATED ☐ NOT WORK RELATED

[redacted] 3770 9/19/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 21 201

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900237

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted]	302	0824	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
3157 Sublette Avenue St. Louis, MO 63139 314-444-0100 Second District

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09-15-17	Tucker & Clark	A.M. 1800 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer was struck with a gatorade bottle filled with an unknown clear liquid irritant. Officer felt a burning sensation on the skin of his chest and arms. Once the situation was under control. Officer was hosed off by the Fire Dept. and returned to duty and the CDT South Patrol line.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☐	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
On the line, facing protestors - CDT

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Unknown

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Chest and arms

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Joseph Carretero, DSN 4343/302	3157 Sublette Avenue, St. Louis, MO 63139 314-444-0100

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
EMS on the scene	N/A

NAME OF SUPERVISOR COMPLETING REPORT
Sgt. Joseph Carretero

RANK SGT DSN 4343

ASSIGN. _____ DATE _____

☒ WORK RELATED ☐ NOT WORK RELATED

Capt. [signature] 5534 9/18/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

SEP 21 2017

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045589

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900238

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	302	11459	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO

3157 Sublette Avenue St. Louis, MO 63139 314-444-0100 Second District

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09-15-17	Tucker & Spruce	____ A.M. 1830 P.M.	NO	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

Officer was struck with a water bottle filled with an unknown clear liquid irritant. Officer felt a burning sensation on the skin of his right arm. Once the situation was under control. Officer was hosed off by the Fire Dept. and returned to duty and the CDT South Patrol line.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☐	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DDING WHEN INJURED?

On the line, facing protestors - CDT

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.

Unknown

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED

Right arm

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SD, EXPLAIN.

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt. Joseph Carretero, DSN 4343/302	3157 Sublette Avenue, St. Louis, MO 63139 314-444-0100

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
EMS on the scene	N/A

NAME OF SUPERVISOR COMPLETING REPORT

Sgt. Joseph Carretero

RANK SGT DSN 4343

ASSIGN. _____ DATE _____

☒ WORK RELATED ☐ NOT WORK RELATED

Capt. [signature] 55th 9/18/17

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

✓

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045994

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900239

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	6531	303	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
[redacted]

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/17/17	N. Tucker & Locust	10:00 A.M. / P.M.	No	12:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

[redacted] was stepping off a bus to deploy for civil unrest in the area and twisted his left knee on some uneven ground.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: CDT gear

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Stepping off bus

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Uneven ground

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Pain and popping in his left knee

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
Unknown

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Lt. Daniel Chitwood 3677	1915 Olive Street; 444-5968

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
Daniel Chitwood

RANK Lieutenant DSN 3677

ASSIGN. 600 DATE 9/18/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT - CITY OF ST. LOUIS

SEP 19 2017

EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045994

INJURY NUMBER *ASSIGNED BY COMMAND POST* (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 170900239

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	6531	303	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

[redacted]

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/17/17	N. Tucker & Locust	10:00 A.M. / P.M.	No	12:00

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

[redacted] was stepping off a bus to deploy for civil unrest in the area and twisted his left knee on some uneven ground.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT gear		

WHAT WAS EMPLOYEE DOING WHEN INJURED?
Stepping off bus

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE.
Uneven ground

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
Pain and popping in his left knee

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, DR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
Unknown

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Lt. Daniel Chitwood 3677	1915 Olive Street; 444-5968

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
Daniel Chitwood

RANK Lieutenant DSN 3677

ASSIGN. 600 DATE 9/18/17

☒ WORK RELATED ☐ NOT WORK RELATED

Lt. Daniel Chitwood 3677 9/18/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

SEP 2 2 2017

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST

☒ BarnesCare on-duty physician immediately contacted by telephone (4:30 p m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045977

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-900242

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted]	446	6318	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO
Division 446, 1915 Olive St. Louis Mo 63103 314-444-5530

DATE OF INJURY	PLACE OF INJURY (NO STREET CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES,TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
8/17/17	14th and Pine/1401 Pine, St. Louis Mo. 63111	9:30 A.M.	No	12PM

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

The employee was attempting to arrest a suspect by placing hands on the suspect. The suspect resisted causing both the employee and suspect to fall to the pavement. This caused a contusion/open wound to the employee's right elbow.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☐	☒
Other Safety Equip. Used?	☐	☒

Specify Type. N/A

WHAT WAS EMPLOYEE DOING WHEN INJURED?
The employee was affecting an arrest.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
The pavement, along with an unspecified chemical directly injured the officer.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED
The officer suffered a contusion/open wound to his right elbow.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN
No.

NAME OF WITNESS. (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Sgt Darnell Dandridge 4207	1915 Olive, Saint Louis Mo. 63103 314-444-5747

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Morrissey, Siobhain NP	Barnescare, 5000 Manchester, Saint Louis MO. 63110

NAME OF SUPERVISOR COMPLETING REPORT
Sgt. Dandridge 4207

RANK Sergeant DSN 4207

ASSIGN 446 DATE 9/19/17

☒ WORK RELATED ☐ NOT WORK RELATED

Lt. Russell Nolan 4681 9/19/17
COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT CITY OF ST. LOUIS

SEP 19 2017

EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) → # 17-045977

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) → # 17-090024

NAME OF INJURED EMPLOYEE	ASSIGN.	DSN	Employee Refused Treatment YES	NO
[redacted]	301	4897	☐	☒

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.

3157 Sublette, St. Louis MO 63139 314-444-0100

DATE OF INJURY	PLACE OF INJURY (NO. STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/17/17	Olive / 13th	___ A.M. 9:31 P.M.	0547	1200

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*

[redacted] squad was inadvertantly deployed several blocks away after a Metro driver followed the wrong bus. PO Kim and his squad "double timed" it to the deployment point, the result of which caused [redacted] to experience chest pain and shortness of breath.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type: CDT Equipment		

WHAT WAS EMPLOYEE DOING WHEN INJURED?

Marching at "double time" to a CDT deployment

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE

Strenuous activity in full CDT Equipment to include a gas mask

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.

Chest pain and shortness of breath

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.

NO

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF ND, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)

YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
Dr. Ghady Ali Rahhal	Barnes Jewish Hospital

NAME OF SUPERVISOR COMPLETING REPORT

Sgt. Charles Wall

RANK Sergeant DSN 6956

ASSIGN. 306 DATE 9/18/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

CHECKLIST:

☐ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☐ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) # 17-045653

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 17-900268

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted]	304	3231	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO.
919 N. Jefferson

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
09/15/17	Kingshighway & Waterman	22:17 A.M. / P.M.	No	0900

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text.*
[redacted] was struck in the head/helmet by a full plastic frozen water bottle thrown by a protester.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐

Specify Type: CDT equipment

WHAT WAS EMPLOYEE DOING WHEN INJURED?
[redacted] was supervising a CDT line formation during a protest.

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE
Full plastic frozen water bottle

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
Momentarily dazed with ringing in ears and neck pain.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.
Unknown

NAME OF WITNESS. (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
Lt. Daniel Chitwood 3677	1915 Olive Street; 444-5968

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEDED)
YES ☒ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	

NAME OF SUPERVISOR COMPLETING REPORT
Daniel Chitwood

RANK Lieutenant DSN 3677

ASSIGN. 600 DATE 10/17/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06

METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
EMPLOYEE INJURY REPORT

OCT 04 2017

CHECKLIST:

☒ BarnesCare on-duty physician immediately contacted by telephone (4:30 p.m. – 8:00 a.m.)

☒ Outlook Message prepared at time of injury and forwarded to Benefits Office and the Director, Human Resources

COMPLAINT NUMBER (WITH POLICE INCIDENT REPORT) #

INJURY NUMBER ASSIGNED BY COMMAND POST (WITH OR WITHOUT A POLICE INCIDENT REPORT) # 170900252

NAME OF INJURED EMPLOYEE	ASSIGN	DSN	Employee Refused Treatment YES	NO
[redacted]	301	7050	☒	☐

INJURED EMPLOYEES' DISTRICT/DIVISION ADDRESS AND TELEPHONE NO

3157 Sublette St. Louis, MO 63139 / (314) 444-0100

DATE OF INJURY	PLACE OF INJURY (NO STREET, CITY, STATE)	TIME OF INJURY	WAS EMPLOYEE EXCUSED FROM DUTY? (IF YES, TIME)	TIME EMPLOYEE BEGAN WORK ON DATE OF INJURY
10/25/17	919 N. Jefferson - Central Patrol Division St. Louis, MO 63106	____ A.M. 1900 P.M.	NO	1600

HOW DID INJURY OCCUR? DESCRIBE FULLY (ATTACH CONTINUATION SHEET IF NEEDED) *Only allow four lines of text*

[redacted] stated that as he was loading onto the Metro bus, dressed in all of his department-issued CDT equipment, when he felt pain in his lower left rib/back.

	YES	NO
Seat Belts Used?	☐	☒
Vest Worn?	☒	☐
Other Safety Equip. Used?	☒	☐
Specify Type:		

WHAT WAS EMPLOYEE DOING WHEN INJURED?

Boarding Metro bus to he deployed into civil unrest area in downtown St. Louis (near/around Busch Stadium).

NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE

[redacted] is not certain of what caused the pian in his lower left rib/back area.

DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED

[redacted] is complaining of pain and soreness to his lower left rib toward the back. Over a 7-day span, PO [redacted] complains that the pain has become more intense and the area more sensitive to touch.

WAS THERE ANY DISMEMBERMENT, DISFIGUREMENT, OR OTHER PERMANENT DISABILITY? IF SO, EXPLAIN.

No

NAME OF WITNESS, (ASSIGNMENT, DSN – IF APPLICABLE)	HOME ADDRESS AND PHONE NUMBER
N/A	3157 Sublette St. Louis, MO 63139 (314) 444-0100

DOES WITNESS CONCUR WITH THE INJURED EMPLOYEES STATEMENT? (IF NO, USE CONTINUATION SHEET FOR STATEMENT, IF NEEOED)

YES ☐ NO ☐

NAME AND ADDRESS OF ATTENDING PHYSICIAN	NAME AND ADDRESS OF HOSPITAL
N/A	N/A

NAME OF SUPERVISOR COMPLETING REPORT

Sgt. Scott Valentine, 5497/608

RANK Sergeant DSN 5497

ASSIGN. 608 DATE 10/3/17

☒ WORK RELATED ☐ NOT WORK RELATED

COMMANDER'S SIGNATURE DSN DATE

MPD FORM HUMAN RES-70 (R-10) 1/06